The Prevention Connection
NEWSLETTER

The Ultimate Rejection: *Surviving Loss by Suicide*

—Celeste Sinton, MD

The suicide death of someone close to you disrupts your life in unforeseen and potentially devastating ways. Whether the suicide was due to hopelessness, anger, anxiety, or despondency, the person who kills himself or herself tells the world that s/he *can't* live anymore. Survivors feel willfully abandoned—it's the ultimate rejection for those who are left. Survivors show many signs of distress.[1] Small reminders can bring back unwanted memories, or the suicide may feel unreal. People might dream about the child or adult who died or feel numb during the day.

Long after the initial shock has passed, questions about life's meaning and purpose will continue to haunt survivors. They may spend many hours asking questions such as, *"How did this happen?"* or *"Why?"* Answers will elude them.

The traumatic loss of a friend or loved one forever transforms your life. Basic assumptions about life's direction, future, and worth are torn asunder, and the priorities of everyday life are scrambled. Things that used to matter no longer do. Survivors feel guilt that they couldn't prevent someone from dying, and experience greater feelings of shame than do survivors of accidental loss.[2] For some, life begins to feel strangely meaningless. When a child dies by suicide, the family is thrown into crisis. Divorce is not only more common among bereaved than non-bereaved married couples, it might seem inevitable.[3] In one study, nearly 70 percent of parents reported that it took three or four years to put a child's death into perspective and continue with their own lives.[4] Grief and bereavement are normal responses to loss. Sometimes mourning can go on for months or years.

Children grieve differently than adults do. Children are more likely to deny the death at first, then grieve intermittently for many years. Because of this, they can suffer emotional disturbances that carry over into adulthood.[5] If the survivor is a parent, it is important to let siblings know that showing emotion is okay. Most children want others to be honest with them about suicide and death. It is best to use simple, direct language commensurate with the child's age and comprehension level. It is comforting for a child to know how different family members will act when they are grieving. Children and adults alike need opportunities to mourn their loss, to say goodbye and get on with living. Schools can help by providing ways for children to talk about their experience when a friend has died by suicide. When talking to children who survive the suicide death of a friend or family member, don't expect a response immediately. Let them know you will be there when they are ready.

In normal bereavement, people continue to work, go to school, take care of family, and enjoy life . . . even through feeling of sadness. The single greatest risk for anyone who survives the suicide death of a loved one, friend or colleague is depression. The risk is that while depressed, people cannot think as rationally as usual, and may begin to have suicidal thoughts. Other signs of developing depression include self-isolation, heightened irritability, changes in normal eating or sleeping habits, poor concentration, indigestion, decreased interest in grooming and lack of interest in activities that used to give pleasure. If the survivor is a child, s/he may

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Individual, Family and Peer Domains

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The Vicki Column

We choose a theme for a quarterly issue of the *Prevention Connection*, then cast a broad net and wait to see what we catch. This time our issue addresses the prevention domains of the individual, peer and family. Interestingly, our net came up with a great deal about suicide and second chances, as well as prevention strategies at work throughout Montana. Between those ends of the spectrum, articles criss-cross a wide continuum. Ordinarily we use the *Vicki Column* to identify the core principles that come to light in any given issue.

This time, I was having a difficult time doing that. What helped me get unstuck was a quote by Eleanor Clift, one of Newsweek's contributing editors. She said, *"If you think of life and death on a continuum, finding the point where it tips is complicated. It cuts across all political lines and gets to the root of our humanity. It requires faith informed by years of intimacy that you're doing what's right for your loved one."* This issue in many ways cuts to the root of our humanity. It speaks to the universal love we have for our children and to the point on the continuum where hope gives out. Identifying where the situation tips is complicated.

Lately, my usually exuberant seven-year-old son has been fading after lunch. His school has called to say that he doesn't feel well. I've gone to get him, and find him so pale that his freckles are popping out. He'll get home, rest for a while, and gradually regain full power until he's raring to go again by supper. There could be any number of explanations—allergies, playing too hard, a personality conflict with another child, frustration with learning materials . . . or he's found my number and is using it to his advantage. I'm not sure what I'm seeing, but at the moment, I'm taking a wait-and-see position, keeping a close eye on him.

This issue of the *Prevention Connection* has brought home the fact that none of us has a clear view into other lives, including those of our children. It has underlined the importance of good communication, steady vigilance, and the need for self awareness. One article in this issue says that the key is noticing when a child's behavior is out of character and suggests that answers will come from talking with our children honestly and with integrity. This requires faith in ourselves, faith that comes from knowing we're doing the very best we can. That's no small thing, but practiced consistently, it may help us move the point where the continuum tips.

Vicki

Student Tobacco Use Down

The 2007 Montana Youth Risk Behavior Survey (YRBS) shows a decrease in the use of tobacco among high school students.

The YRBS asks 13 questions related to tobacco use among high school students. Nearly every question shows a decrease over the past 10 years. In 1997, 19.3 percent of high school students reported having smoked a cigarette on 20 or more of the past 30 days. This year, that number was down to 8.1 percent. That's a 58 percent decrease in frequent smoking rates.

Although the trend data is encouraging, it is important to continue implementing school-based programs and to secure the additional resources that will help keep rates on the decline. According to the Campaign for *Tobacco Free Kids*, the tobacco industry spends $41.8 million each year marketing in Montana.

Some successful school-based activities include educating students to prevent initial use by teaching about health risks and resisting peer pressure, incorporating media literacy into curricula and engaging students in advocacy events to change the social acceptance of tobacco use.

The YRBS has been administered statewide in odd-numbered to a random sample of students since 1991. To view tobacco survey results go to: www.opi.mt.gov/PDF/Superintendent TobaccoUse07.pdf.

For more information, contact Tara Jensen, Communications Director for Superintendent Linda McCulloch at 406-444-3160.

Involving Youth in Suicide Prevention

—Char Windhausen

Suicide is the second leading cause of death among youth ages 15-24 in Montana. Only unintentional injuries such as car accidents, drowning and fires kill more Montana youth. It is estimated that every suicide directly impacts at least six people. This tragedy strikes the entire family, friends, peers and, often, the entire community. The Montana Mental Health Association (MMHA) has initiated a youth-led suicide prevention project in a statewide effort to reduce youth suicide by involving youth in creating outreach projects.

Many youth suicide prevention activities are planned and implemented with little or no input from youth. *This* youth suicide prevention project addresses that problem. The project gets kids to develop media projects that carry a suicide prevention message using the types of communication most familiar to them, including text messages, social networking sites like *MySpace*, as well as video broadcasting sites like *You Tube*. The result? Teens connect with the messages because teens created them.

Teens and young adults are more likely to share feelings of depression and thoughts of suicide with their friends than they are with the adults in their lives. This is why MMHA's media project focuses on peer-to-peer outreach. The goal is to educate young people about the signs of depression or potential suicide, and teach helping strategies. This is one of the first steps in creating communities capable of dealing with depression and suicide.

The first step of the project is to provide youth with QPR (*Question, Persuade and Refer*) training. This offers basic knowledge about recognizing the signs of potential suicide and helps ensure an appropriate response if someone expresses suicidal thoughts. Youth learn to ask directly about suicide, persuade the person to get help and refer to a trusted adult.

The second step of the project is to connect youth with local media experts. Youth will receive training on effective media presentations and how to use technology to create them. The youth will come up with a project that uses any type of media they wish. The projects will be screened by an advisory before being sent out to the public.

The MMHA is offering a $250 cash prize for the best advertisement and two $100 prizes for runners-up. Winners will be determined by a panel of suicide prevention experts from around Montana. If your school, youth group or prevention coalition is interested in participating, or if you are interested in volunteering your media expertise, call Char Windhausen at the Montana Mental Health Association at 877-927-6642 or email *char@montanamentalhealth.org*.

Surviving Loss by Suicide

Continued from cover

refuse to do schoolwork or to go to school. With any of these symptoms, it is important to seek professional help right away. There is no need to suffer, as there are many forms of therapy and medication available.

Preventing suicide is a challenge that will never be mastered as long as there are those who seek death as a solution to their life's problems. But you can prevent *illness* in the aftermath of a suicide death by being alert to the needs of the survivors and the progress of your own bereavement, and by seeking professional help when you recognize that you aren't going on with living in a satisfactory way.

—Dr. Celeste Sinton works for Shodair Children's Hospital in Helena. Shodair serves children and adolescents who suffer from emotional, mental and behavioral problems through four treatment programs—the acute unit, the children's unit and two adolescent units. Shodair is a leader in childhood psychiatric treatment and genetic disorders. They are a national resource that provides integrated care in the areas of diagnosis, research, education, prevention, and treatment. For more information, visit www.shodairhospital.org/.

Surviving Loss by Suicide

Sources Cited/Great Resources:

[1] *The Impact of Event Scale was developed in 1979 by Horowitz, Wilner and Alvarez to help people measure the significance of subjective distress to a traumatic event, such as a suicide.*

[2] *Seguin M, et.al., Parental bereavement after suicide and accident: a comparative study; Suicide Life Threat Behavior, 1995.*

[3] *Murphy SA, et.al., Challenging the myths about parents' adjustment after the sudden, violent death of a children; Journal of Nursing Scholarsh., 2003.*

[4] *Murphy SA, et.al., Bereaved parents' outcomes 4 to 60 months after their children's deaths by accident, suicide, or homicide: a comparative study demonstrating differences; Death Studies, 2003.*

[5] *An excellent book for parents and relatives of children who survive the suicide death of a family member or friend is How Do We Tell the Children? by Dan Schaefer and Christine Lyons. It contains a wealth of knowledge and practical advice that covers issues related to helping children who are exposed to death and dying.*

Preventing Youth Suicide

—Karl Rosston, LCSW

—The key to recognizing the symptoms is that the youth is acting out of character.

By any standards, adolescence is difficult. Teenagers are dealing with a transitional period between childhood and adulthood. They are constantly looking at the world around them and learning how they fit in. Their relationships, emotions, bodies and minds are all changing. For many adolescents, this much change can be overwhelming. Uncertainty and fear of failure can become preoccupations, and some will choose to numb feelings with drugs and alcohol. Others rebel and become full of rage.

Because of a growing need for independence and self-reliance, many adolescents find it difficult to express the emotions consuming them, perhaps out of fear of being viewed as a failure by their peers and families. For those unable to adapt, the pain can become so intense that they see taking their own lives as the only solution. Suicide among the young is becoming epidemic.

In Montana, suicide is a serious health issue. According to the Montana Department of Public Health and Human Services:

— For the past 20 years, Montana has ranked in the top five for suicide rates in the nation for all age groups. In a report released in January of 2008 by the American Association of Suicidology, Montana was number one in the nation in the suicide rate.

— Suicide is the number one cause of preventable death among Montana children ages 10-14.

— Suicide is the number two overall cause of death for young people, ages 15-34.

Suicidal ideations are often associated with factors such as depression, social isolation, undesirable life events and early parental loss. Somewhere near ninety percent of the youth who attempt suicide suffer from mental illness. The most frequent diagnosis is depression, followed by alcohol dependence. Family stress is a major factor of suicidal behavior in youth. Along with the presence of an underlying depression, there is also a correlation with a history of suicidal behavior by parents, domestic violence and high levels of family stress. Family stress may mean that youth do not feel validated, understood or accepted by their families.

Youth who make suicide attempts present a devastating picture. Seventy to ninety percent of attempted suicides involve drug overdose, although this is rarely the sole cause of death. Both genders prefer overdose, but males tend toward violent means such as guns and hanging. Males are four times more likely to *complete* a suicide than females, but females attempt suicide three times more frequently than men. However, according to the Center for Disease Control, in recent years there has been an increase in the number of young woman using suffocation as a means of suicide.

Every kid is unique, so identifying symptoms can be challenging. For this reason, it is key to treat them as individuals. An accepting, non-judgmental manner and being straightforward may pay off with incredible dividends.

Many people avoid the topic of suicide with youth for fear of planting the idea. This is a serious mistake. If you have concern about someone's safety, it is best to ask if s/he is feeling suicidal or if s/he's had thoughts of self-injury. Most youth will

Remember:

- ***Reach out. Asking the suicide question does not increase risk.***
- ***Listen. Talking things out can save a life.***
- ***Don't try to do everything yourself. Get others involved.***
- ***Don't promise secrecy and don't worry about being disloyal.***
- ***If persuasion fails, call your mental health center, state hotline or emergency services.***

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According to the Surgeon General, Center for Disease Control, and the American Association of Suicidology:

— Suicide is the third leading cause of death for young people between the ages of 15 and 24, right behind unintentional injury and homicide.

— In recent years, more teenagers and young adults have died of suicide than from cancer, heart disease, AIDS, birth defects, stroke, pneumonia and influenza, and chronic lung disease combined.

— A person under age 25 completes suicide every 2 hours and 11 minutes. This equates to 12 young Americans each day.

— Firearms remain the most commonly used suicide method among youth, accounting for 49% of the suicides completed.

— Most adolescent suicide attempts are precipitated by interpersonal conflicts.

— Nationwide in our high schools:

• 17% of young people consider suicide;

• 13% reported creating a plan;

• 8% attempt suicide (about 1 million kids);

• Of those, 161,000 young people receive medical treatment for their suicide attempt; and

• Approximately 4,600 die by suicide.

Youth Suicide

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respond honestly. The question will often validate the feelings they are experiencing. Avoiding the question reinforces the youth's feelings that people do not understand what s/he is experiencing.

Some people who think that suicidal ideation is an attention-getting device, but *all suicidal ideations must be taken seriously*. The last thing you want to do is minimize someone's feelings or put him in the position of proving himself. Whether you think the suicidal ideation is genuine or an attempt to get attention, it is still a cry for help. If the person is suicidal, opening the conversation could prevent an attempt.

The bottom line? People who are suicidal are not going to be helped by lectures or given 100 reasons to live. They need to have their feelings validated and know that they have someone who they can turn to when they need help. Just remember: *suicide is a permanent solution to a temporary problem.*

Meet Karl Rosston: *Montana's New Suicide Prevention Coordinator*

Karl Rosston has a very personal interest in suicide prevention. He's a survivor. Karl was 20 at the time his sister died by suicide at age 27. She'd just graduated from Washington State University in Veterinary Medicine. Unfortunately, talking about mental health issues had been taboo in their family, so it was only later that Karl learned his sister had been struggling with anorexia and clinical depression.

Karl also has a strong professional interest. He'd graduated with a degree in psychology from the University of Montana and had received an MSW from the University of Denver. Before returning to Montana, he worked on suicide prevention and assessments at the University of Colorado, where he was an instructor for several years. After that, he spent time as the Director of Social Services at Shodair, where he applied for—and received—a grant to do suicide prevention training for teachers. The training he did exposed him to the issue of suicide in towns and schools throughout Montana.

What he found was a sense of desperation. Small communities have so few resources that a great deal of the burden is put on teachers and public health nurses. Many schools talked about a breakdown in family dynamics, where the parents are either absent or struggling with their own issues. Kids begin to use drugs and alcohol to cope, which only creates more isolation and hopelessness. The issue in rural Montana is that once these kids begin to fall, there's no support system to recognize the signs.

Karl believes we have to change the stigma associated with mental illness and suicide, and that we have to learn that it is okay to talk about suicide. Our state is full of independent, proud people—it's one of our greatest strengths. But the "cowboy up" mentality and the denial can result in the loss of our greatest resource—our youth, our future.

As the new Suicide Prevention Officer for the Department of Public Health and Human Services, Karl's goals include stabilizing Montana's Suicide Hotline, which will mean increasing the funding and ensuring that the program meets national standards. He'd also like to explore additional school-based interventions and using mass media to increase public awareness. Karl can be contacted at KRosston@mt.gov.

"With my sister, I found out afterwards that she had made two previous attempts that I knew nothing about. She didn't know how to use a firearm and had to go back to the store and be shown how to use the gun. Where is the awareness? The warning signs were there." **– Karl Rosston**

Signs

In working with youth, it is imperative that the adults involved are able to recognize the warning signs of suicidal thinking. The following are some of the more common.

- *Abrupt change in personality*
- *Giving away prized possessions*
- *Increase in drug/alcohol use*
- *Disturbance in sleeping and eating*
- *Inability to tolerate frustration*
- *Isolating from peers or family*
- *Decrease in communication*
- *Sexual promiscuity*
- *Decline in personal hygiene*
- *Complaints of being bored*
- *Overall sense of sadness and hopelessness*
- *Decrease in academic performance*
- *Difficulty concentrating*
- *Recent family disruption*
- *Recent history of running away*
- *Abrupt end to a romance*

Seeds of Hope

—Stephanie Iron Shooter

There is a deep-seated belief that the root of the American Indian suicide problem is intergenerational trauma and attempted genocide. But what does that mean?

Our culture is important because you must figure out who you are first and where you come from to figure out where you are going.
—Laurie Meyers

Imagine you are sitting at home with your family, comfortable and happy, maybe watching television until suddenly someone breaks into your home. With a gun to your heads, your family is ordered to go to a place the intruders designed, in a location they think is better. You can no longer be yourselves, follow your customs, practice your religion. You can only be who they tell you to be and stay within the boundaries they've set for you. Sounds unimaginable, doesn't it? Well, that's exactly what happened to our ancestors.

Imagine the pain of watching your world fall down around you. What would you do? Is it possible that you'd drown your sorrows with a bottle of vodka, a needle of methamphetamine . . . suicide?

Data underlines the result of the shame and trauma that have trickled down through the generations. According to the 2005 Youth Risk Behavior Survey (YRBS), suicide attempts among Native Americans in Montana high schools on the reservation are approximately 16.6 percent, nearly double the U.S. average of 8.8 percent. This survey also revealed that 56.3 percent of Native American youth currently use alcohol.

Tribes once had a lifestyle that was positive and empowering; we had hope. We strive today to revive our culture, to show our children that they can be proud of who they are and where they came from.

In order to address these astounding statistics, the tribes are challenged with the task of building their communities so that our most important "seeds" can be nourished to grow into empowered individuals.

Part of the mission of the Montana-Wyoming Tribal Leaders Council is to enlighten each other about our peoples, and to otherwise promote the common welfare of all of the Indian Reservation peoples of Montana and Wyoming. In support of this mission, the MT-WY Tribal Leaders Council is working to address the issue of suicide among tribal youth through the *Planting Seeds of Hope* project, funded through a Substance Abuse and Mental Health Services Administration (SAMHSA) grant. Our initial funding year began in June 2006 and will continue through May 2009. This project, a direct collaboration between tribes and tribal colleges in Montana and Wyoming, will continue through May 2009.

The *Planting Seeds of Hope* project will educate and train everyone possible in suicide prevention programs such as Question-Persuade-Refer (QPR), Acquired Suicide Intervention Skills Training (ASIST), and the American Indian Life Skills Development Curriculum. All of these programs will allow the tribal communities to educate people to directly engage those who are suicidal and refer them appropriately so that they can get help.

Each tribe will be able to tailor its suicide prevention strategies to their individual culture and beliefs with the assistance of the community, including tribal leaders, tribal elders, Indian Health Service, Police, youth serving organizations, schools, churches and others.

Suicidal behavior and substance abuse are just two of the problems that haunt our people. We must also consider the interrelated issues of poverty, family violence and crime. This project will also assist in developing and maintaining working clinical teams in each community so that gaps around assessment and referral for many issues become smaller.

In the end, we hope our communities will be able to revive and embrace tradition so that the issues that plague us can be ameliorated and so that, as a people, we can move forward to live life with hope rather than just survive.

For more information, contact the Montana-Wyoming Tribal Leaders Council at (406) 252-2550 or visit www.mtwytlc.com.

QPR

You do not need to be a mental health professional to help someone who is suicidal. Anybody can help. One method being taught is called QPR (Question, Persuade, Refer). QPR is not therapy, it is a way of offering hope.

— Question the person about suicide. Ask, Do you have thoughts? Feelings? Plans? Don't be afraid to ask.

— Persuade the person to get help. Listen carefully. Then say, Let me help, Or Come with me to find help.

— Refer for help. A child or adolescent should contact an adult or parent. Call a minister, rabbi, tribal elder, teacher, coach, counselor, or law enforcement officer.

Notes from the Edge: *Understanding PTSD*

—Tom Huddleston

—I learned that PTSD is a normal reaction to a series of abnormal events.

The latest Defense Department reports tell us that up to 35 percent of the men and women who have returned from deployment to Iraq and Afghanistan are showing signs of Post Traumatic Stress Disorder (PTSD). This syndrome first came to the public's attention as an aftermath of the Vietnam War. It's estimated that 15 percent (480,000) male Vietnam veterans have been diagnosed and/or treated for PTSD. The newly established diagnosis in the *Diagnostic and Statistical Manual of Mental Disorder* finally gave an identity to symptoms therapists had known about and treated for years.

While returning veterans need attention, we can't overlook the vast numbers of non-veterans who struggle with PTSD. By some estimates, 23 percent of American women have been raped at some point during their lives and over half will eventually develop PTSD. Every year, an average of two million people in the United States experience injury and property loss from natural accidents and disaster. Estimates vary, suggesting that anywhere from 5 to 20 percent of Americans experience significant abuse (physical, sexual, or emotional) as children. All of these traumas can be as damaging as those experienced in war.

Symptoms of PTSD include sleep disturbance, anxiety, depression and isolation—all of which describe the realities for those who have known trauma. Traumas are imprinted in the thalamus: the multi-dimensional camera of the brain. PTSD can lead to a roster of failed relationships, failed vocations, substance abuse, homelessness and suicide attempts. I know about it first hand: I am one of the 480,000 Vietnam veterans with PTSD.

I was diagnosed in 1979 and slid instantly into denial for fear that family, friends and my employer would find out and think less of me. Even when averaging two hours of sleep a night because I feared my dreams, I hid from the diagnosis. When I found myself needing the adrenal rush of bar fights, I hid from the diagnosis. After treatment for substance abuse, I still denied it to others and to myself. The social stigma attached to mental illness and co-occurring disorders lays heavily upon the lives of those affected.

I was fortunate. In 2002, doctors at Fort Harrison referred me to the VA's National Center for PTSD for three months, and then to the five-week PTSD program at the Boise VA Medical Center. I learned that PTSD is a normal reaction to a series of abnormal events. I was given tools to keep me from falling into the familiar holes of isolation and depression. I have a support group that I can go to twice a week. I also have a compassionate therapist to work with twice a month and a Psychiatrist who monitors my medication. In a crisis, I know that one phone call will muster up an army of caregivers and support.

But what of my non-veteran neighbors who suffer with PTSD? What about the parents, spouses and families of those suffering from PTSD? Where can *they* go? In Helena, there's no PTSD support group for them. There's just one support group in *Montana* for female vets. Ironically, the program being implemented by the Montana National Guard and emulated by the military reserve components stationed in Montana might be the vanguard for the development of supportive groups beyond the programs of the VA.

I'm thankful for the VA and what it has done, is doing now, and what they're planning to do. I'm thankful that the Governor and the Guard's Adjutant-General assessed their policies and identified areas needing change. I believe that they are serious and sincere about implementing the Task Force's recommendations. I especially like their call to identify and treat PTSD as a wound worthy of respect. I'm encouraged by the Social Workers of Montana who recently called for and presented a symposium on PTSD. Even so, there's an important piece missing.

Non-veterans whose lives are crippled by trauma and PTSD, as well as their spouses and families, need support groups to help them learn, accept and get their lives back, and they need them now, not later.

—Tom Huddleston was appointed by Governor Brian Schweitzer to the Montana Board of Veterans Affairs as well as the Montana Council on Homelessness.

Symptoms

People with PTSD may startle easily, become emotionally numb (especially in relation to people with whom they used to be close), lose interest in things they used to enjoy, have trouble feeling affectionate, be irritable or become aggressive.They avoid situations that remind them of the original incident. Anniversaries of the incident are often very difficult.

PTSD symptoms seem to be worse if the event that triggered them was deliberately initiated by another person, as in a mugging or a kidnapping. Most people with PTSD repeatedly relive the trauma in their thoughts and in nightmares. These are called flashbacks. Flashbacks may consist of images, sounds, smells, or feelings triggered by ordinary occurrences, such as a door slamming or a car backfiring on the street. A person having a flashback may lose touch with reality and believe that the traumatic incident is happening all over again.

PTSD affects about 7.7 million American adults, but it can occur at any age, including childhood. Women are more likely to develop PTSD than men, and there is some evidence that susceptibility to the disorder may run in families. PTSD is often accompanied by depression, substance abuse, or one or more of the other anxiety disorders.

Source: National Institute of Mental Health. Post Traumatic Stress Disorder. www.nimh.nih.gov/health/publications/anxiety-disorders/post-traumatic-stress-disorder.shtml

Second Chance Parenting

—Marty Smith

Haven't we all wished for that second chance to do something? To redo a job interview . . . retake a test . . . try kicking the ball for that field goal one more time? What if we were asking to have second chance to parent our children in an environment where they can grow into healthy, happy adults and productive members of our society.

Five years ago, the Parenting Place heard the cries of an invisible group of Montana children left behind by incarcerated parents. We found their parents in our jails and prisons, sometimes hundreds of miles away. These parents are eager to learn how to communicate with their children during the time they are separated and to better provide for their needs when the family is reunited. The Parenting Place meets the families where they *are* and helps identify—and build on—their strengths.

We offer parenting classes in the Missoula Pre-Release Center and the Missoula County Detention Facility. During our ten-week sessions, parents have the opportunity to explore their own childhoods and consider how those early experiences have affected their choices. The process of revisiting their childhoods makes parents more aware of how their actions affect their children. They work hard to develop strategies to change their behavior and to learn the parenting skills that will preserve their families.

Many researchers say that developing a strong bond with the family is the single most important factor in preventing recidivism.

The Parenting Place offers more than parenting classes for incarcerated parents. We embrace the entire family. Our goal is to empower each individual: the child, the caregiver *and* the parent.

Caregivers are often frustrated and angry. Most face financial difficulties as they try to manage the household on a single income. They often become overwhelmed with the emotional demands of single parenting. The Parenting Place provides caregivers a place to vent and problem solve. Caregivers are also offered a break through our Respite Program. One evening a week they can bring their children to our center for a nurturing meal and fun activities.

When children are grieving the loss of a parent, it is sometimes difficult for them to focus on anything else. They often struggle in the classroom, at home and with their friends. Children process grief in different way, which can result in behavioral changes that range from withdrawal to aggression. Our program offers children support at home, in school and the opportunity to visit with the incarcerated parent at our center. During the visit, families can prepare and enjoy a meal together, play outside in our fenced yard, read a book or just snuggle in our *comfy corner*.

During incarceration, each person in the family changes. Children grow up, caregivers become more independent and incarcerated parents have an opportunity to learn from their mistakes. Whatever changes families face, their greatest challenges lie in reunification. The Parenting Place is there throughout the reunification process to help the family learn to develop healthy, nurturing environments.

According to Department of Corrections data, about 48 percent of adult male offenders return to a correctional institution within three years of release; about 47 percent of adult females return within three years*. The 500 families who have completed our program during the past five years have a recidivism rate of just 14 percent. This reduction means that nearly 1,000 children are thriving *at home*.

This program has been funded in part by the Montana Children's Trust Fund. The Parenting Place has recently partnered with the Billings Family Tree in an effort to assure continuity of services across the state to families touched by incarceration.

*Data source: http://www.cor.mt.gov

—Marty Smith is the Program Manager of the Parenting Place in Missoula. For more information, go to http://www. parenting place.net/

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The Science of Mental Illness

A new finding could one day help identify people at risk of adult depression triggered by childhood stress. Certain variations in a gene that helps regulate response to stress tend to protect adults who were abused in childhood from developing depression, according to new research funded by the National Institute of Mental Health. Adults who had been abused as children but didn't have the variations in the gene had twice the symptoms of moderate to severe depression, compared to those with the protective variations.

—See the NIH News Release at: www.nih.gov/news/health/feb2008/nimh-04.htm

Youth who will develop psychosis can be identified before their illness becomes full-blown 35 percent of the time if they meet widely accepted criteria for risk, but that rises to 65 to 80 percent if they have certain combinations of risk factors. Knowing what these combinations are can help scientists predict who is likely to develop the illnesses within two to three years with the same accuracy that other kinds of risk factors can predict major medical diseases, such as diabetes.

—Full NIH News Release at: www.nih.gov/news/pr/jan2008/nimh-07.htm

Children and Domestic Violence

—Kerrie Wheeler, LCPC

In the past decade, a great deal of attention has been paid to domestic violence. The internet is full of links to information and services for victims. Until very recently, however, the effect of domestic violence on children has been secondary.

Each year in this nation, an estimated 3.3 million children are exposed to violence by family members. Many studies indicate that in homes where partner abuse occurs, children are more likely to be abused as well. This may be due to the fact that 40-60 percent of men who abuse women also abuse children.

Study after study shows that over half of female victims of intimate violence live in households with children under age 12, which is a strong indicator that services focused on children should continuously screen for risk factors and symptoms of domestic violence. Professionals should be aware of these signs and report their suspicions to child protective services. In Montana, a centralized intake system allows reporters to call, anonymously, 24 hours a day, 365 days a year.

Children from violent homes recreate the abusive dynamic, which is about power and control. The abuser feels threatened by any attempt on the part of the victim to be independent of the relationship. We hear a great deal about the extreme cases that lead to physical assault or even homicide, but most domestic violence begins much more subtly. The perpetrator demeans the victim in intimate ways that often go unnoticed by family or friends. There is a constant threat of violence or abandonment, even if it is never acted out. Victims commonly report feeling crazy, because the abuser twists their words and motives for every action into something hurtful or disloyal to the relationship. Victims also report feeling responsible for the violence, because the abuser tells them that it is their fault for not complying with basic rules . . . all of which are created and enforced by the abuser.

Verbal and emotional abuse can be just as damaging to a child's development as witnessing physical violence. Some children identify with the perpetrator and take on those character traits. These children may act out physical aggression and/or verbal and emotional abuse of younger, smaller or more passive peers. This is typically referred to as bullying.

Other children take on a more passive role. This can manifest in two basic ways. Some youngsters solicit attention through victimization. They will report recurrent events in which they are victims of bullying or cruel behaviors by friends. Like the aggressive child, these problems are typically easy to spot by those trained to recognize the behavior. However, some children who place themselves in the victim role isolate from their peers and even from the adults around them. When asked why they are not engaging with others, they will typically complain that the other children don't like them or are being mean, but they are not likely to tattle. These children are often unnoticed, because they tend to follow rules and do not usually bring attention to themselves.

Obviously, not every aggressive or passive child is living in a home where domestic violence is an issue. But even when that seems to be a reasonable suspicion, it is important not to use that as an excuse for the child's inappropriate behaviors. After all, children are human, and humans learn from the natural consequences of their decisions. *Especially* if you suspect a child is living with domestic violence, s/he needs to be held accountable and allowed to experience the natural consequences of his/her choices. Another mistake that is often made by well-meaning adults is to tell the child that his or her parents are wrong in the way they interact. Children are fiercely loyal to their parents. The best way to address behaviors they've learned at home is to explain that those behaviors are just not acceptable anywhere else. Eventually, children will determine, on their own, whether or not hurting someone who trusts them is acceptable behavior.

—Kerrie Wheeler is a licensed clinical professional counselor (LCPC). She holds one Master's degree in Human Services and another in Counseling. She is a child and family therapist, specializing in childhood trauma and domestic violence, with more than ten years experience working with families who have children with special needs.

Montana PDQ

PDQ is a customized database developed for tracking domestic and sexual violence statistics in Montana. Programs receiving DV/SA funding are required to file quarterly reports that include demographic information on victims, the crimes they've suffered and services provided. The Montana Board of Crime Control (www.MBCC.mt.gov) and the Montana DPHHS (www.DPHHS.mt.gov) fund the project. At this point, data is available for years 2002–2005.

2005 PDQ Data

— *There were 18,279 upduplicated victims of sexual and domestic violence:*

- *14,244 primary victims; and*
- *4,035 secondary victims.*

— *Alcohol and/or drugs were a contributing factor for 6,927 victims.*

— *Victims received 244,666 units of service.*

— *Orders of Protection were approved for 1,287 victims.*

— *Ultimately, 1,482 victims filed for separation or divorce.*

For more information, visit the Montana Coalition Against Domestic and Sexual Violence at www.mcadsv.com.

The Dawson County Parent Resource Center (PRC) is a project of the Montana Children's Trust Fund. It is located in the basement of the Glendive Public Library. The PRC houses its own catalogue of 538 volumes including audios, books, family games and videos. Classes and various support groups are held throughout the week, ranging from meetings for the parents of newborns or children with Serious Emotional Disturbances (SEDs) to grandparents raising grandchildren.

Parents can enter the week they need services. Classes are designed to meet a variety of needs, including parenting challenges, kinship care, training for day care providers, foster care, or professional credits. The PRC also provides a parenting class at the local corrections facility and on an outreach basis to other counties and organizations. In some cases, Dawson Community College can award free credits.

If you need more information, contact Pete Bruno, Parent Resource Center, weparent@midrivers.com or call 406.377.7515.

Tantrums

—Pete Bruno

When I inherited the Dawson County Parent Resource Center, they had just added three *Active Parenting* (AP) curricula. I became responsible for teaching AP as well as *Love & Logic Parenting* (LLP) every week. As the weeks went by, I discovered that the AP and LLP curricula are designed to reduce family stress and prevent child abuse by making parenting fun and by making handling the problems children present something to look forward to—even to the point of *hoping* they occur.

The prevention-oriented design is clearest when it comes to understanding, accepting and handling tantrums. The need for focusing on handling tantrums as a special parenting subject apart from regular classes became a reality when three different couples in three consecutive days asked, *"How should I handle tantrums?"*

All five of our parenting curricula agree on the way to handle tantrums. First, the reality is that tantrums are *a* if not *the* very young child's normal reaction to frustration. We also know that children who see adults showering attention, bribes, gifts and/or rewards in response to tantrums learn to change frustration tantrums into temper tantrums for fun and profit.

The risk of abuse is heightened when a parent is tired and unprepared for normal fits of crying or the protracted tantrum for secondary gain. From the medical model we know that a drug *reaction* is bad while a drug *response* is good. But high levels of emotion are contagious, so it is natural for the parent to be unready to respond rather than react. To help, we have special monthly *Baby & Me* classes for parents of newborns, who must cry to express their needs, as well as ongoing Early Childhood classes to prepare parents with toddlers who tantrum.

It is no surprise that parents need special strategies to make the transition from handling a normal infant's trust-building cycle (*crying and thrashing brings Mommy to help by changing my diaper, feeding or cuddling me*) to handling a toddler's behavior when it takes the form of a temper tantrum.

Managing Tantrums

When your toddler drops to the ground, kicks, screams and/or pounds things (or you) during a tantrum, here is what you do:

1. Stay calm—don't get pulled in emotionally.
2. Step back—if the child is safe, let the tantrum finish. Don't fight it or give in.
3. Talk gently—when you see it dying down and want to get involved, be soothing and understanding.
4. Hold gently or firmly—gently when it is dying down, firmly to the point of restraint if the child is in danger. Even then, talk soothingly.
5. Never offer rewards or give into demands. Disregard comments of others such as, *"But he's just a little kid!"*
6. Offer a choice—if the tantrum is interfering with something say, *"Either take a few deep breaths and calm yourself down,"* or *"Finish yelling in your room,"* and gently walk or carry him to his room if he does not do as instructed. If in public, take her outside and/or home.

Our video lessons illustrate many examples of how parents should give choices and consequences at home and in public, including many in-process choices such as, *"Do you want the door open or closed?"* If the child runs out of the room, the response might be, *"Oh how sad, you chose door closed."* When all interventions are done empathically and even cheerfully, children learn that their parents can handle them without breaking a sweat, are loving people and that their personal discomfort is rising from their own choices and consequences.

Both Active Parenting and Love & Logic curricula make their strongest safety and anti-abuse statements when teaching parents how to handle tantrums. They remind us that parenting is the primary relationship in which human beings learn to choose between violence and personal integrity. When we take a class, team up with others and show calm, intentional and intelligent problem solving in response to the challenges kids bring, we teach them the calm, intentional and intelligent problem solving skills that they are likely to use in their own relationships and families.

Introducing RTEC

"Boyd Andrew is one of the leaders in the state handling chemical dependency issues. They are keenly aware of the state's needs . . ." —Joan Cassidy, Chemical Dependency Bureau Chief

The Department of Public Health and Human Services has hired Boyd Andrew Community Services to manage the state's seven new long-term residential treatment facilities for low-income citizens. The centers are located throughout the state and have come together to form the Resident Treatment Expansion Consortium (RTEC). The Consortium is comprised of separate state approved chemical dependency treatment programs working together, but administered and managed by Boyd Andrew Community Services. All sites will be gender specific, with the exception of the detox/stabilization services provided by the Rimrock Foundation. The facilities will only be open to adults.

The first site opened in January, at Rimrock Foundation in Billings. During the next few months, additional sites will begin offering services in Great Falls, Rocky Boy, Boulder, Miles City, Kalispell and Bozeman. Programs with facilities in those communities will contract with Boyd Andrew to operate the centers.

According to Chief Executive Officer Mike Ruppert, there have been long waiting lists in Montana for services like these. The RTEC will ensure that those who need help can access it much more quickly.

At the request of Governor Brian Schweitzer, the 2007 Legislature appropriated $4 million to fund the project. "Treatment works," Governor Schweitzer said. "These centers will provide a stable environment for those who desperately need help to battle their addiction."

RTEC Centers share a common belief that residents will benefit by the opportunity to live on-site, away from the environments that fostered their addictions. Even so, there are some significant differences among the centers. Rimrock Foundation and Elkhorn Treatment will provide intense treatment that can include up to ten hours of counseling per day. Those who come to these centers require a more restrictive environment. The other centers will provide a supportive environment for clients who don't need as much supervision or counseling.

The five single-sex centers are essentially Recovery Support Homes, with access to intensive outpatient treatment. They promote life skills, and must have adequate employment opportunities for residents. Case managers will work with clients to help them develop soft skills such as how to manage a job interview or create a résumé. Case managers will also help facilitate job placement. Two of the five facilities are designed specifically for Native American populations, and these will have access to culturally appropriate recovery resources.

Each facility will offer treatment programming that combines the Minnesota Treatment Model in a therapeutic community milieu, combined with a variety of cognitive behavioral therapies including Dialectical Behavioral Therapy; Wanberg and Milkman's curriculum, *Criminal Conduct and Substance Abuse Treatment: Strategies for Self-Improvement and Change* and strength-based case management. All RTEC facilities will implement elements of the Matrix Model, motivational interviewing and contingency management. Finally, all RTEC facilities will measure and account for the cognitive impairment that is a hallmark of methamphetamine addiction.

Although the centers target methamphetamine addicts, they will also serve those in need of treatment for alcohol or other drugs. The costs to clients will be based on a sliding scale, depending on their ability to pay. In general, those admitted into the program will have had minimal criminal involvement and will be motivated to recover. Because recovery is a lifelong process, clients will receive follow-up care once they return to their homes.

One interesting aspect of the programming is its focus on providing gender-specific and co-occurring capable programming. There is also vocational and abuse programming, with a specialized group for the victims of trauma.

In all cases, the ideal treatment process consists of pretreatment and stabilization followed by three phases:

1. Treatment initiation;
2. Abstinence attainment; and
3. Maintenance with long-term support.

Mike Ruppert is optimistic that success rates will exceed expectations. RTEC programs are co-occurring capable, and they focus on specific problems rather than taking a general approach. The mission is to give people the tools they need to make healthy choices. By providing appropriate treatment in the right environment and for the right amount of time, people are able to return to a point where they have real choices in their lives.

The $4 million requested by Governor Schweitzer was the first general fund money designated for community-based drug and alcohol treatment programs. This contract is also unique in that Boyd Andrew has been trusted to design and administer the system.

RTEC is expected to be a very wise investment. Treatment not only works, it is highly cost effective, with some studies showing a benefit-to-cost ratio of up to 7:1. This could add up to significant fiscal savings, but the savings in terms of lives restored, families reunited, and people returned to productive citizenship is priceless.

—Sue Rajacich is the newly hired Program Manager for the RTEC. She comes to the project from Western Montana Mental Health in Missoula. For more information, call Sue at 447-5080 or e-mail her at SRajacich@boydandrew.com.

Boyd Andrew is a nonprofit corporation that has offered chemical dependency services for the past 35 years in Lewis and Clark, Broadwater and Jefferson counties. The agency also operates the Helena Prerelease Center and the Elkhorn Treatment Center in Boulder.

Environmental Prevention

—The recognition of the problem of underage drinking and building new efforts to address this issue are very important to me. I'm hopeful this funding will help reduce the devastating impacts this problem continues to have on our communities.

—Governor Brian Schweitzer

According to DPHHS officials, the Strategic Prevention Framework State Incentive Grant (SPF SIG) will provide funding focused on preventing binge drinking and drunk driving for people of all ages, with a special focus on youth.

"The harmful effect this issue has on Montana families is immeasurable," says Joan Miles, Administrator of the Department of Public Health and Human Services. "This grant will allow the recipients to take a hard look at alcohol-related issues in their communities and it will give them the tools to do something about it."

Six communities were chosen to participate in creating solutions consistent with the premises of *Environmental Prevention*. The SPF SIG will fund county- or reservation-wide efforts to utilize the five step Strategic Prevention Framework process to develop a *data driven, comprehensive, coordinated* and *sustainable* prevention plan. This plan will implement community- and evidence-based environmental strategies with an emphasis on youth that addresses lifespan binge drinking with an emphasis on youth as well as lifespan drinking and driving. Recipients will spend the first six months identifying the alcohol-related issues within their communities and determining how those issues influence minors.

For example, organizations might study issues such as how alcohol is served at community functions, or training tavern owners on how to avoid serving minors. In the end, communities will create their own solutions. Organizations will work with county commissioners, law enforcement and school superintendents to mitigate local problems associated with substance abuse. The goal is to understand the problems associated with substance abuse and to come up with solutions.

The Environmental Prevention Model is comprised of five interdependent components or strategies. In order to achieve sustainable, systemic change, a project must address all five components.

1. ***Media advocacy*** is the critical element that links model components into a cohesive whole. Awareness of the problem is raised through print and broadcast stories, which provide a vehicle for a high-visibility community response, including highlights of project successes and demonstrations of community support. All promote policy change.

   Media advocacy puts issues on the public agenda. Appropriate community members, including youth, become spokespeople and are trained on strategic media, from letters to the editor to opinion pieces and feature stories, in addition to electronic media. Authentic community voices spark public debate and discussion, while clarifying problems and solutions.
2. ***Applied data and research*** is utilized at all stages of a campaign to identify the magnitude of a problem, create issue briefings, assess readiness, guide program direction and evaluate outcomes. Essentially, data collection supports the need for community interventions, demonstrates change and brings prevention science closer to communities. Data is collected through surveys, polls, focus groups and key informant interviews.
3. ***Community organizing*** builds support among youth and adult community members and organizations, businesses, law enforcement agencies and policy-makers by engaging them to create positive change. Bringing the right people together at the appropriate time results in new policies and other positive changes.
4. ***Policy development*** supports changes in environmental and community conditions. Policy implementation drives campaign strategies and media plans. Policy change can take many forms, from policies, practices or procedures within organizations to the implementation of new laws.
5. ***Enforcement*** ensures consistent application of new and existing policies, practices and procedures within a prevention system. Community participation in monitoring is essential for effective policy.

Long-term, sustainable change requires a comprehensive approach integrating all of these components.

Continued on Page 13

The following organizations will be funded for a 3.5-year period.

— Havre HELP Committee

— District II Alcohol and Drug Services

— Blackfeet Housing

— Butte-Silver Bow County Health Department.

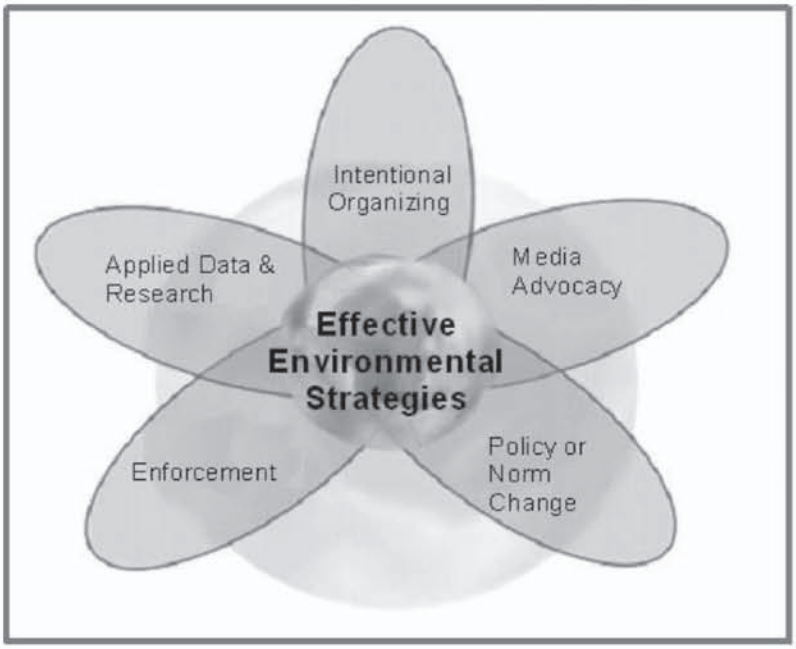
— Jefferson County Sheriff's Department

— Flathead Reservation and Lake County Coalition for Kids

Environmental Prevention *continued*

The Strategic Prevention Framework is grounded in the public health approach and based on six key principles.

1. ***Prevention is an ordered set of steps along a continuum*** to promote individual, family, and community health, prevent mental and behavior disorders, support resilience and recovery and prevent relapse. Prevention ranges from deterring diseases and behaviors, to delaying the onset of disease and mitigating the severity of symptoms. Ultimately, this reduces the related problems in communities. This concept is based on the Institute of Medicine model that recognizes the importance of the whole spectrum of interventions.
2. ***Prevention is prevention is prevention.*** That is, the common components of effective prevention for the individual, family or community within a public health model are the same—whether the focus is on prevention or reducing the effects of cancer, cardiovascular disease, diabetes, substance abuse or mental illness.
3. ***Common risk and protective factors exist for many substance abuse and mental health problems. Good prevention focuses on common risk factors that can be altered.*** Family conflict, low school readiness, and poor social skill increase the risk for adolescent substance abuse, delinquency and violence. Protective factors such as strong family bonds, social skills, opportunities for school success, and involvement in community activities can foster resilience and mitigate the influence of risk factors. Risk and protective factors exist at the individual, family, community and the broader environmental levels.
4. ***Resilience is built by developing assets in individuals, families and communities through evidenced-based health promotion and prevention strategies***. Youth who have relationships with caring adults, good schools, and safe communities develop optimism, good problem-solving skills and other assets that enable them to rebound from adversity and go on with life with a sense of mastery, competence and hope.



5. ***Systems of prevention services work better then service silos.*** Working together, researchers and communities have produced a number of highly effective prevention strategies and programs. Implementing these strategies within a broader system of services increases the likelihood of successful, sustained prevention activities. Collaborative partnerships enable communities to leverage scarce resources and make prevention everybody's business.
6. ***Baseline data, common assessment tools, and outcomes shared across service systems can promote accountability and effectiveness of prevention efforts***. A Strategic Prevention Framework can facilitate the efforts of federal agencies, states, communities and reservations to identify common needs and risk factors, measure and track results and target outcomes. A data-driven strategic approach, adopted across services systems, maximizes the chances for future success positive outcomes.

Moving the Strategic Prevention Framework from vision to practice is a strategic process that state and community stakeholders must undertake in partnership. Through the SPF SIG, Montana will provide the requisite leadership, technical support, and monitoring to ensure the identified communities are successful.

The SPG SIG grant is distributed by the Center for Substance Abuse Prevention (CSAP), a federal agency that works with states and communities to develop comprehensive prevention systems that create healthy communities. Montana joins 32 other states that have received SPG SIG funds. The Chemical Dependency Bureau of the Addictive and Mental Disorders Division of the Department of Public Health and Human Services will administer the $11.6 million grant, of which 85 percent will be available for community-based, environmental prevention strategies that address lifespan binge drinking and lifespan drinking and driving, both with an emphasis on youth.

Ultimately, through integrated prevention, communities will increase their ability to achieve targeted outcomes and develop infrastructure and capacity to address these priorities. These efforts will support the State's ability to prevent and reduce binge drinking and drinking and driving, and will build global prevention capacities and infrastructure at State and community levels.

For more information, call Jackie Jandt at 406-444-9656 or contact her by e-mail at JJandt@mt.gov .

Families and Child Care Providers . . . *in Partnership*

—Jamie Palagi

Child Care Resource & Referral Agencies in Montana

Billings: HRDC District 7 (247-4732)

Hardin: HRDC District 7 (665-1895)

Glendive: DEAP CCR&R (377-4909)

Kalispell: The Nurturing Center (756-1414)

Bozeman: Child Care Connections (587-7786)

Great Falls: Family Connections (761-6010)

Lewistown: HRDC District 6 (538-7488)

Butte: Butte 4 C's (723-4019)

Havre: District 4 HRDC (265-6743)

Miles City: DEAP CCR&R (234-6034)

Glasgow: Hi-Line Home Programs (228-9431)

Helena: Child Care Partnerships (443-4608)

Missoula: Child Care Resources (728-6446)

To learn more about the Child Care Resource & Referral Agency in your area, please visit www.childcare.mt.gov.

Parents are a child's first teachers, but while some parents can stay home with their children, others must consider their options for child care. Options range from informal care by family, friends and neighbors, to formal care through licensed or registered child care facilities. Regardless of the choice, one thing is certain: parents want the best possible care for their children.

Many working parents understand first-hand the challenge of finding quality child care. As parents begin this quest, many go through a litany of criteria to determine which child care program is the right place for their children. *Is the program licensed or registered by the State of Montana? Do the hours of operation meet my scheduling needs? Is the location close to my house? How many children are in care? Do they have fire evacuation plans and do they practice fire drills? What kinds of child development activities are available for my child to participate in? What is the facility's discipline policy? How do they handle medications? How often does the staff turn over?* The list can go on and on.

Pick up virtually any magazine geared to new parents and you will probably find some type of checklist or article focusing on child care. Businesses exist to assist families in their journey of finding the right placements for the children of working parents. In Montana, these businesses are called Child Care Resource & Referral Agencies. They provide referral lists based on criteria the parent sets, including location, costs and hours of care. Other services provided by these agencies include assistance with child care scholarships for qualified families, child care provider training and technical assistance, community services and family support services.

The Formula for School Readiness:

Ready Families + Ready Communities + Ready Services + Ready Schools = Children Ready for School.

Child care providers serve as valuable partners in raising children. Parents must feel confident that the child is well cared for, safe and provided with optimum chances for development and learning. In addition, most families want a provider who is willing to respect and model the family's values and beliefs. Strong partnerships between parents and child care providers build valuable protective factors and foster resiliency at even the youngest ages.

In the past few years, those in the early care and education field have begun to talk about *school readiness*. School readiness emphasizes the importance of communities working together to best meet the needs of very young children.

School readiness does not mean that children know their ABCs and 123s and are therefore ready to enter the public school system. School readiness means that the community at large—with all its services, including schools—are ready to support children and meet their needs at each developmental level. Focusing on school readiness is another way of looking at building strong protective factors for children and families with young children. A child's readiness for school should be measured and addressed through development: physical well-being and motor development, social and emotional development, approaches to learning, language development, cognition and general knowledge. When parents and child care providers work together in support of these developmental areas, both contribute to a child's growth.

In addition to building partnerships with individual families, child care providers can serve as a vehicle for families to establish strong relationships and bonds with one another. Children develop close friendships while in care and parents, too, can begin building a strong support system among themselves. Child care providers can foster relationships by providing volunteer and interactive opportunities for parents.

Choosing quality child care is not easy, but by looking at child care through the perspective of partnership, the outcomes are positive for all involved.

—Jamie Palagi is Chief of the Early Childhood Services Bureau of DPHHS. She can be reached at JPalagi@mt.gov.

The Challenge: *Providing Good Nutrition on a Limited Budget*

—Minkie Medora

We have all seen the cost of food rise steadily for the past two years. Eating healthy meals within the family food budget, even with home-cooking, has become a serious challenge for middle class families. For the poor and hungry, the struggle has become critical. About 44,000 Montana families deal with this each month. Many live on the financial edge. The slightest change in the family's economic situation can mean an overnight drop into poverty or worse.

The Montana Food Bank Network's second study of clients in food pantries *Hungry in Montana* found that people with limited incomes spend their money for essential bills like shelter, heat and transportation, then hope there is money left for food. When that is not possible, families must often make difficult and painful choices to cope with hunger and food insecurity.

Food insecurity has been defined as limited or uncertain availability of nutritionally adequate and safe foods or limited or uncertain ability to acquire acceptable foods in socially acceptable ways.

— Families with children make sure the kids have enough food to eat, while adults frequently skip meals.

— Parents start to cut food costs, purchasing cheaper foods that relieve hunger. This could mean foods that are calorie dense, higher in fat and sugar or snack foods that have a lot of salt and fat.

— When all else fails, the amount of food given to children is reduced.

— A last resort is often the local food pantry for emergency food boxes. Most food pantries in Montana allow clients to come once a month. Each food box can last a family for three to seven days.

Montanans who lack food security are very concerned about the nutritional quality of food they feed their families. Their circumstances often mean that they don't have the luxury of making the right food choices, despite their best efforts.

There is growing evidence on the paradox of food insecurity, poverty and obesity. Hunger in America often equates with poor- and under-nutrition. This means that while a person may have a fair quantity of food to eat, the foods eaten are high in calories and low in nutrition. This causes deficiencies of essential vitamins, minerals, protein and fiber. Too many calories, saturated fats and sugars increase the risk of several diseases. When that happens, there is a cascade of consequences generated by lack of access to high-quality food.

Poorly nourished infants and children have slower physical growth and mental development. They are more likely to have anemia, leading to reduced cognitive skills in school. They are also more prone to sick days. It has been well documented that overall academic achievement is impaired by poor nutrition. Adults with poor diets are at greater risk of developing diabetes, heart disease and other chronic diseases, as well as overweight or obesity. Seniors and single adults living on fixed incomes, in isolated parts of the state, end up living on tea and toast or going without.

As food dollars run out near the end of each month, hunger becomes acute. When food dollars become available, families buy more food, but feel the need to eat it fast. This feast or famine approach creates changes in the body that lead to greater fat stores. If the food purchased is calorie dense to begin with, that exacerbates the problem, leading to obesity.

It is inconceivable that food insecurity persists in America. The public food assistance programs are excellent resources, but they are not the answer in and of themselves. Communities must focus on the overarching economic needs of the family, provide a livable wage for working families and a safety net for those unable to work.

—Minkie Medora, MS, RD is a board member of the Montana Food Bank Network. For further information, contact minkie.medora@gmail.com

Food Insecurity

The defining characteristic of very low food security is that, at times, the food intake of household members is reduced and normal eating patterns are disrupted because the household lacks the resources to access food. Very low food security can be characterized in terms of the conditions these households typically report.

— *98% worried that their food would run out before they got money to buy more.*

— *94% could not afford to eat balanced meals.*

— *95% reported that an adult had cut the size of meals or skipped meals because there was not enough money for food; 85% reported that this had occurred during 3 or more months.*

— *46% had lost weight because they did not have enough money for food.*

— *33% reported that an adult did not eat for a whole day because there was not enough money for food.*

Source: Food Security in the United States: Hunger and Food Security. November 2007: www.ers.usda.gov/Briefing/FoodSecurity/labels.htm

Become Media Literate!

—Will Michael, PhD

In this information age of entertaining cell phones, iPods, Blackberrys, and portable DVD players, media is literally everywhere you go, almost as present as the air we breathe. Just as air can be clean and fresh and good for us—or polluted and potentially harmful—media can have a positive or negative impact. Because media plays such an important role in impressing and impacting our youth, understanding media and how it works is an important area of mental health education, substance abuse prevention and psychological self-defense.

We live in a country that honors and protects our First Amendment rights to free speech. While this is right and good, it has a downside when it comes to understanding the neurolinquistic effects of media exposure. Media can feed our minds with violent ways to solve problems via movies and TV, sexist, hate and angst driven lyrics in rap songs, magazine ads that suggest you're not a real man unless you smoke Marlboros or drink a particular brand of beer, or news of the worst examples of human behavior around the globe, 24 hours a day. Given these circumstances, the only thing we can and should do is to educate, enlighten and empower the recipients of this type of information to become critical thinkers. Thinkers can then know they are responsible for making conscious choices based on an educated interpretation of the media they allow into their minds, hearts and souls. We call this type of awareness *Media Literacy*.

In addition to my role as a Prevention Specialist with Rocky Mountain Development Council, I have been a student and teacher of neurolinquistics and hypnosis for over 35 years. From this perspective, I have been fully aware of how important it is to live in a society that values personal responsibility and the right and privilege of choice. In order to be fully in a position of conscious choice, one has to gain an understanding of the principles of suggestion and how they work in communication and the media.

Media projected from mediums that affect masses of people allow the creation of what is known as *cultural hypnosis*. The value or danger of this phenomenon is largely in the beholder and the degree to which s/he is vulnerable to the subconscious or meta-messages of the communications. Even the creators of media messages are often unaware of what is being suggested on deeper levels – or how those suggestions will impact the recipient. This is referred to as *unintentional hypnosis*. Media literacy protects our youth from the unwanted and potentially harmful affects of cultural or unintentional hypnosis.

Becoming media literate means that instead of passively receiving media, we gain the ability to actively and knowledgeably examine its messages, metaphors and images. Media literate people are critical thinkers who are able to analyze, evaluate and use media very consciously. They recognize the bias, misleading suggestions and underlying values being projected. Being media literate also instills a greater ability to appreciate and enjoy media. Being media literate means using media to affect the social consciousness of the community around you. This is also called *social marketing*.

Through the efforts of the *Youth Connections Coalition* (YCC), media literacy curriculums are in place throughout the Helena Public School District. Students are excited about this area of study. The Media Literacy and Social Marketing Subcommittee of the YCC has also taken the project further to create the M Gen Fest, an annual showcase of social marketing products created by students as a result of their media literacy lessons. The PEAK program in Helena also created a media campaign, which was presented last year in the Rotunda of the State Capital and then on TV, radio and billboards around Helena. If you would like to know more, contact the Youth Connections Coalition at 406-324-1078.

—Will Michael, PhD, is a Prevention Specialist and the Director of the Clinical Hypnosis Institute of Montana. He is also the chair of the Media Literacy/Social Marketing Subcommittee of the Youth Connections Coalition. He can be reached at wmichael@rmdc.net.

Tobacco statistics highlights

— The percentage of students who have ever tried smoking is down 29 percent; from 73 percent in 1997 to 52 percent in 2007.

— Regular use (i.e., smoked at least one cigarette a day for 30 days) has decreased from 23 percent in 2001 to 13 percent in 2007 (a 44 percent change).

— In 1997, 21 percent of students reported using chewing tobacco, snuff or dip in the past 30 days. Now the number of students using smokeless tobacco is 13 percent, a 45 percent drop.

Source: YRBS www.opi.mt.gov/PDF/Superintendant/ Tobacco use 07 pdf

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The Eye of the Beholder

—Jeffrey W. Linkenbach, Ed.D.

—Those who are successful at directing the public's perception of what is normal and acceptable are also those who will largely determine future health and safety trends. —Linkenbach, 2001

We can document that people have been aware of the negative effects of alcohol use for centuries. The strategies used to impact alcohol abuse have run a gamut of philosophies and experiments in social policy. In 1327, the English tried (and failed) to control drunkenness by limiting the number of establishments that could sell alcoholic beverages. Six hundred years later, America enacted prohibition, which, by all accounts, failed in its attempt to apply a simple solution to a complex social problem. When prohibition died in 1933, buried with it was the hope that a single policy could ensure the improvement of social behavior.

Dozens of other strategies have also been tried—increased penalties, advertising restrictions, taxes and price controls, to name a few. Perhaps, though, the one element essential to social change has not been given the attention needed to effect real change. That element is *perception*.

What we *believe we see* shapes our behaviors and attitudes. That means that effective long-term solutions must include strategies that steer public perceptions about alcohol from hype and fiction to fact. In so doing, we will be able to transform the social norms attached to the use of alcohol.

Although there are many definitions, social norms can be framed as the behaviors or attitudes of the majority. For example, if most people in a community do not drink, then not drinking is the social norm. *Perceptions* of social norms are what people believe about the behaviors or attitudes of their peers. If the majority perceives that most people drink to excess, then drinking to excess is the *perceived social norm*. Perceptions of social norms are strong predictors of future health behavior, because people tend to behave the way they believe is most typical or accepted.

The fact is, most of us make positive decisions about health and safety. We drink in moderation, wear seatbelts and are drug and tobacco free. Even so, the common perception of our peers' risk-taking behavior is remarkably exaggerated. These are *misperceptions of social norms*.

Many studies have been published demonstrating that misperceptions positively correlate with drinking behavior or predict how individuals drink. Misperceptions about alcohol consumption can have profound impacts on prevention and enforcement. If people believe the majority overuses alcohol, the social norm appears to oppose the laws designed to reduce dangerous drinking. The fact of the matter is that our laws support and enforce behavior that is already in practice by the majority.

Several factors contribute to the misperceptions of social norms. While we are good at observing others' behavior, we aren't nearly as good at interpreting what we see. We tend to think that unusual behaviors exhibited by others are typical or characteristic because we may not observe people often enough to contextualize their behavior. Another reason is that casual conversation tends to focus on extreme escapades or high-risk behaviors. Stories may be exaggerated to make them funnier or more dramatic, but this can lead to the perception that such actions are more prevalent than they really are. Even those who are *not* engaging in dangerous behaviors can spread the misperception through repetition.

The third factor contributing to misperceptions of social norms can be attributed to the influence of the media, which carries the most dramatic, arresting or shocking stories of the moment. Vivid or emotionally evocative information increases the impact on perceptions, leading to exaggerated ideas about prevalence. The result? People worry about sociopaths with guns while the most common killers are obesity, heart disease, cancer and stroke.

Misperceptions have significant consequences. Those who might not otherwise practice a high-risk activity such as excessive drinking might engage in it if they perceive it to be the norm. Those who are already drinking heavily might wrongly conclude that their behavior is acceptable and practiced by the majority. This could reinforce their existing tendency to make poor choices. And finally, intervention efforts can be inhibited in an environment characterized by widespread misperceptions. It is very human to avoid risking social disapproval by being the odd person out.

The social norms approach to prevention shapes human behavior by correcting misperceptions and identifying the disparity between perceived and actual social norms. Social norms programs focus on the positive majority behavior or attitudes that are almost universally the norm, rather than the negative behavior and impacts of the minority. This strategy corrects misperceptions of social norms to more closely correspond with actual norms. This, in turn, leads people to make their choices in accordance with the actual, positive, social norms of the community.

—Linkenbach, Ed.D. is a Senior Research Scientist in the Department of Health and Human Development at Montana State University, and Director of the National MOST Of Us Institute for Social Norms. For more information, visit http://www.mostofus.org.

VISTA Site Applications

Prevention Resource Center (PRC) VISTA site applications are due in March and September each year. Visit the PRC website for details. www.prevention.mt.gov

Teen Birth Rates Up

Preliminary birth data shows a significant increase in the Montana teen birth rate between 2005 and 2006. *"The state birth rate increased 9 percent last year, marking the biggest single year increase since 1990,"* said Colleen Lindsay, Supervisor of the Women's and Men's Health Section for DPHHS. The teen pregnancy rate increased statewide by more than three percent.

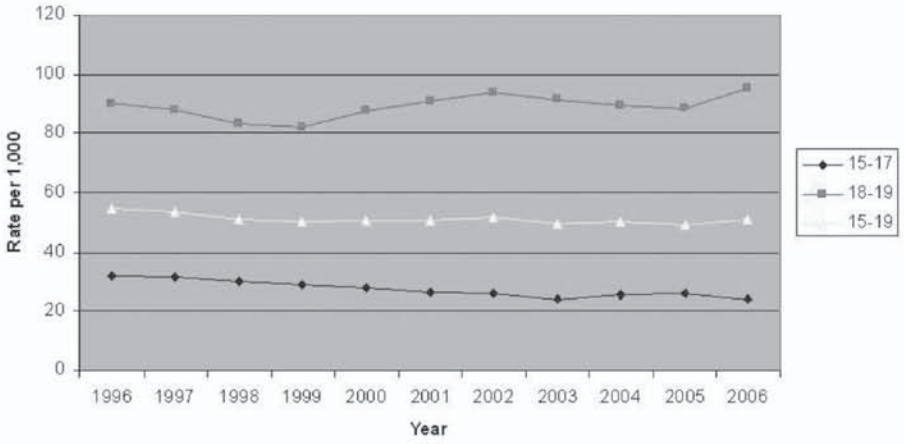
Montana's teen pregnancy and teen birth rates have historically been below the national average, but the gap may be closing. Before 2006, Montana's birth rate had been relatively stable, recording its lowest level in 1999 at a rate of 36 per 1,000 teens. Montana's current birth rate is 40 per 1,000 teens, compared with the national rate of 42 per 1,000 teens.

"It's too soon to determine the exact cause of the increase and whether or not it is a sign of a new trend." Lindsay says. *"What we can say for sure is that there will not be one simple answer, but many factors that influence teen pregnancy and birth."*

DPHHS will analyze state data for their upcoming report, *Trends in Teen Pregnancies and Their Outcomes*, scheduled for publication during Teen Pregnancy Prevention Month in May 2008. Staff will analyze risk and protectic factors that include when teens have sex, how many sexual partners a teen reports, whether or not they were using alcohol or drugs during sex, and what contraceptive services they access and use to protect themselves from pregnancy.

According to Colleen Lindsay, studies indicate that families and communities are the most influential people in a teen's life.

Teen Pregnancy Rates, Single Year



If you would like to learn more about MAPPS, its members and guiding principles visit: www.missoulaforum,org/coalitions/mappps/index.html.

For more information on risk and protect factors associated with teen pregnancy, visit: http://www.teenpregnancy.org/resources/data/report_summaries/emerging_answers.

For teen pregnancy and birth data, visit: http://www.dphhs.mt.gov/PHSD/Women-Health/teenpreg-index.shtml.

Compared to other semi-urban areas of the state, Missoula County's 3-year teen pregnancy rate has consistently been the second lowest in the state, behind Gallatin County. DPHHS staff want to take a deeper look into what is working in communities like these. For this reason, the upcoming report will not only highlight data, but will feature a sampling of teen pregnancy prevention programs from across the state, such as the Missoula Adolescent Pregnancy, Parenting, and Prevention Services (MAPPPS), a coalition under the umbrella of the Missoula Forum for Children and Youth.

The mission of MAPPPS is to develop a community strategy for the prevention of teen pregnancy and to address the special needs of pregnant and parenting teens. MAPPPS was formed in 2000. Its members believe that two issues helped propel its recent success: grant funding rising from a thorough needs assessment and capacity-building activities, and the addition of a VISTA, sponsored by the Prevention Resource Center, who assists with program coordination.

"Because so many of our members have full-time jobs, a VISTA has been an essential part of our coalition," says Angel Nordquist, Health Educator with Planned Parenthood.

The coalition has enhanced collaboration and broken down silos.With the added boost of funding and staff, MAPPPS has adopted guiding priniciples, outreached to new members, and completed an action plan outlining goals from proving training to its members, to creating user-friendly fact sheets, to passing legislation.

"It's been helpful to break our work down into subcommittes," says Mizner. *"Our work is more efficient that way. Because the members tend to gravitate to areas they already have knowledge in, there's less of a need to orient members to the subject matter and jargon."* Currently, MAPPPS subcommittess include Services, Legislation and Prevention.

All of the members are proud of the work they've done, and all agree that there is much more to do, including seeking more data relative to the ways pregnancy affects a student's ability to complete their education.

GUTS!

—Jen Euell

Girls Using Their Strengths (GUTS!) is a unique, community-based leadership and empowerment program designed by and for young women, ages 9 to 18. GUTS! was started by the Missoula non-profit, *Women's Voices for the Earth* in 1997, and today is a program of the YWCA Missoula. GUTS! works to empower young women by incorporating proven best-practices, such as mentoring, long-term experiential learning, community service learning, small group discussion, single gender programming, and physical activities to foster positive change. We provide connections to school, community and nature through the different components of our programming.

Currently our *Girls in Action* groups meet weekly throughout the school year at nine local schools and two community locations. They build strong peer and mentor relationships, and provide the opportunity for deeply personal change. By utilizing techniques that encourage girls to identify their strengths and move toward understanding the strengths of their peers, Girls in Action groups create an opportunity to develop respect for diversity.

GUTS! partners with community organizations such as the National Coalition Building Institute, Missoula in Motion and Free Cycles for monthly Community Adventures. Community Adventures provide girls from different schools and neighborhoods a chance to get to know one another, and to connect with their community through service learning projects.

Outdoor Summer Adventures incorporate outdoor skills such as backpacking, canoeing or rock-climbing, while introducing participants to the GUTS! leadership method. These trips provide a unique environment free from social pressure. Girls have the opportunity to really think about who they are, recognize their strength and potential, set personal goals and learn to work with other girls as part of a team.

GUTS! recently added the Young Women LEAD (Leadership Enhancement and Development) Project. Over the last four months, the GUTS! Girls Advisory Council, a group of several longtime members, has met on a weekly basis to develop the new LEAD Project for high school aged girls. In February, a number of talented local women began sharing their knowledge and skills on topics including decision-making, public-speaking, organizing, facilitating meetings and more. Each participant will design a community project in an area of particular interest to her, gaining hands-on leadership experience. The Girls Advisory Council envisions LEAD as a place for girls to meet and grow relationships with adult mentors, learn valuable skills . . . *and* have tons of fun!

Through the different program components, GUTS! helps girls use their voices to activate positive community change. We encourage participants to be effective leaders in promoting environmentally and socially responsible behavior in their communities and in their world.

For more information or to inquire about participation in this program, please visit www.ywcaof missoula.org or contact: Jen Euell GUTS! Director at the YWCA Missoula (406) 543-6691 or by e-mail to jeuell@ywca ofmissoula.org.

Misuse of Over-the-Counter Cough and Cold Medications

About 3.1 million Americans between the ages of 12 and 25 (5.3 percent of this age group) have used over-the-counter cough and cold medicines to get high at least once, according to a report by the Substance Abuse and Mental Health Services Administration (SAMHSA).

Newly analyzed data from the National Survey of Drug Use and Health (NSDUH) show the number is comparable to those who say they have used LSD (3.1 million) and significantly greater than the number who reported having tried methamphetamines (2.4 million).

Overdosing on cough and cold medications may result in serious, even life-threatening adverse reactions including blurred vision, loss of physical coordination, intense abdominal pain, vomiting, uncontrolled violent muscle spasms, irregular heartbeat, delirium and death.

Although non-prescription cough and cold medications are generally safe when taken for medicinal purposes and as directed, they can induce severe dissociative, out-of-body experiences when consumed in amounts far in excess of recommended dosages. These reactions are similar to the effects of the well-known hallucinogens phencyclidine (PCP) and ketamine (Special K).

The full report on non-prescription cough and cold medication is available on the Web at *http://oas.samhsa.gov/2k8/cough/cough.cfm*. Hard copies can be obtained free of charge by calling SAMHSA's Health Information Network at (1-877-726-4727). Request inventory number NSDUH08-0110. For related publications and information, visit *http://www.samhsa.gov.*

The Power of Networking

—Alyssa Lindsay

Richland County, in Eastern Montana, is a traditionally underserved, frontier area. In rural areas such as ours, the development of resources and social support systems can be challenging simply due to the vast geography. Over the past several months, the Richland County Family Resource Center has been working to provide families with social supports ranging from parent education to appropriate agency referrals. While we have learned many valuable lessons throughout the resource development process, networking with other agencies, more than anything else, has been key to our success.

The Richland County Family Resource Center originated through a collaboration between District II Alcohol and Drug Program, the Richland County Public Library and the Richland County Coalition Against Domestic Violence (RCCADV). The purpose of coming together was to find a way to fill noticeable gaps in family support and education services. Many organizations within Richland County, including Child and Family Services (CFS), youth probation and local courts, have expressed their concern about child abuse in the community. Other entities, such as schools, the public library and the Health Department had an interest in family-strengthening supports on behalf of their service populations. Needless to say, there was an obvious concern regarding this gap in services.

In 2006, CFS received 82 reports of child abuse or neglect in Richland County.

The last community-wide parent education program in our area was eliminated in 1998 due to budget cuts. This past year, the Richland County Coalition Against Domestic Violence began filling the gap by offering the *Nurturing Program*, which provides parent education. Unfortunately, the RCCADV was unable to sustain the parent education program, so the Richland County District II Alcohol and Drug Program stepped up to continue it and to implement additional programs through the Family Resource Center. In order to efficiently provide these services and reach the greatest number of at-risk parents, District II collaborated with the Richland County Public Library in providing a resource loan library and the Parenting Wisely CD-Rom program, in a neutral, public location.

Following this groundbreaking collaboration, the Family Resource Center has gone on to network with many other community agencies to ensure the efficacy and sustainability of family support and educational services. One organization that has been extremely helpful in ensuring our success is the Richland County Boys and Girls Club. They have provided free classroom space in which to hold classes each week. In addition, we have formed partnerships with our district judge and youth probation office, both of which have provided support by distributing information about our programs and services. Along similar lines, CFS has agreed to display information about our program and refer appropriate clients. These organizations have helped form a strong referral network that continues to benefit the resource center.

Another highlight has been networking with local churches and services organizations. Through their generosity, we have been able to provide the Nurturing Program participants with a meal at each class. Further, in contacting these organizations, we were able to make many individuals and community leaders more aware of the Family Resource Center. These contacts have proven very beneficial, and we continue to receive phone calls and questions about the resources available.

While networking and collaboration can be challenging, it is arguably a crucial strategy for smaller communities to experience success.

*—Alyssa Lindsay is a Communities in Action AmeriCorps *VISTA with the District II Alcohol & Drug Program of the Richland County Family Resource Center. She can be reached at 406.433.4097 or AlyssaLindsay@hotmail.com.*

Great Resources on Childhood Precursors to Substance Abuse

Learn more about protective factors and the 40 developmental assets on the PRC website at www.Prevention.mt.gov.

— Adolescent Alcohol and Drug Use Predicted by Early Childhood Behavior? Society for Research in Child Development, Psych Central News: http://psychcentral.com/news/2006/07/13/adolescent-alcohol-and-drug-use-predicted-by-early-childhood-behavior

— Early Childhood Behavior Could Predict Adolescent Substance Use. Child Development, www.jointogether.org.new/research/summaries/2006/early-childhood-behavior

— Physical Aggression During Early Childhood: Trajectories and Predictors. Pediatric Publications, http://pediatrics.aappublications.org/cgi/content/full/114/1/e43

— Risky Behavior in Teens with ADHD. Charles and Helen Schwab Foundation. www.schwablearning.org

— Early Childhood Behavior and Temperament Predict Later Substance Use. http://www.nida.nih.gov/NIDA_Notes/NNVOL10N1/Earlychild.html

— A Coordinated Response to Child Abuse and Neglect: The Foundation for Practice. Child Information Gateway. http://www.childwelfare.gov/pubs/usermanuals/foundation/foundationf.cfm

Prevention Works

—Abby Harnett

—Prevention is better than cure. *—Desiderius Erasmus*

Good prevention can reduce the risk factors associated with interpersonal violence, bullying and child abuse. In support of this goal, we offer a variety of comprehensive programs for area youth.

Area schools are an essential venue for the prevention efforts of Sanders County Coalition for Families (SCCFF). During the school year, child advocates become constant fixtures in classrooms countywide. We offer an assortment of workshops designed specifically for students in Kindergarten through grade 12. Topics include peer relationships, healthy communication, bullying, dating violence, sexual abuse, harassment or other topics based on the specific needs of individual schools.

One of our most requested youth services is the *Art Expression Program.* Art is used as a means of safe communication that allows children between the ages of five and ten creative opportunities to explore topics such as anger, family dynamics, safety and self-esteem. For six weeks, children gather as a group where they develop skills that they can go on to utilize in everyday life.

SCCFF has created several programs in response to the growing epidemic of bullying. In addition to resources such as brochures, websites and informational flyers, we have built child-friendly bulletin boards displayed in each Sanders County school. SCCFF child advocates present prevention lessons and have developed a series of puppet shows for Kindergarten through second grade.

Prevention efforts at the high school level center around our PEACE Program. Teen volunteers of PEACE (Peers Educating and Advocating for Changing Expectations) act as a support group to educate their peers on issues surrounding dating violence, sexual assault and harassment. Volunteers focus on outreach through distribution of informational materials and by scheduling motivational speakers who can reach teenagers. The PEACE Program promotes leadership skills and commitment to social change.

New additions include the Girls Club, which supports girls who have been exposed to domestic violence and educates them (and their peers) about the dangers and types of domestic violence. This group of 5th and 6th grade girls learn about topics important to girls in this transitional stage of development. The Girls Club will be a safe place to share struggles and seek solutions to problems. The second new addition provides internet safety and education courses for students, teachers and parents. With the increased technological sophistication of youth, this is an area of growing concern. A featured speaker from the University of Montana will share his expertise on topics relevant to computer-savvy youth, including online predators, cyberbullying, e-mail, instant messaging and chat rooms, online gaming, social networking and more.

The SCCFF also focuses prevention efforts that touch the lives of children through parenting classes. The Nurturing Skills Classes are 8-week long parent and child education classes designed to create family communication, cooperation, closeness and respect. Parents participate with their children to cover topics including self-awareness, empathy, discipline alternatives and age appropriate expectations. We also provide a traveling resource center that allows SCCFF to offer resources such as books, educational games, DVDs and videos to rural communities in our area. The ultimate goal is to reduce child abuse in Sanders County.

SCCFF is committed to prevention at a number of levels. Educating children *before* they begin to engage in negative behaviors, creating programs for children who are at risk, and providing youth with skills and resources that they can really use all support a healthy, safe lifestyle. Children are the key to the future. Helping them thrive and succeed is our responsibility.

—Abby Harnett is the Youth Services Coordinator for the Sanders County Coalition for Families. She can be reached in Thompson Falls at 406-827-3218 or abby@sccff.org.

Underage Drinking

Although drinking by persons under age 21 is illegal, people between the ages of 12 and 20 drink almost 20 percent of all alcohol consumed in the United States. Age at onset strongly predicts development of alcohol dependence over the course of the lifespan. About 40 percent of those who start drinking at age 14 or under develop alcohol dependence at some point in their lives; for those who start drinking at age 21 years or older, about 10 percent develop alcohol dependence at some point.

In 2006, Montana reported 22,186 motor vehicle crashes; 226 were fatal crashes resulting in 263 fatalities. Of these, 126 (48 percent) were alcohol-related deaths; 108 (41 percent) involved blood alcohol concentrations (BAC) of 0.08 or higher.2

For more information, see the January 2008 report, Risk Behaviors of Montana Youth Involved with Alcohol based on the 2007 Montana Youth Risk Behavior Survey. www.opi.mt.gov/PDF/YRBS/AlcoholReport2007.pdf

Tribal Leaders Battling Drug Abuse

The Substance Abuse and Mental Health Services Administration (SAMHSA) has funded the Rocky Mountain Tribal Access to Recovery (RMT ATR) with $5.7 million over the next three years. The mission is to address the gaps and barriers that impede access to a continuum of care that is culturally competent and effective for American Indians. The RMT ATR offers a unique opportunity to increase access to treatment and recovery support services for our communities.

RMT TAR will provide an additional funding stream for chemical dependency treatment and recovery support services for American Indians in Montana and Wyoming. Recovery Support Services are culturally responsive wrap-around services, and can include transportation to and from chemical dependency treatment, child care, mentoring, nutrition, and other services to help recovering people stay clean and sober. Limited funding for residential treatment is included in this grant, but the primary focus will be upon providing supplemental outpatient and recovery support services.

Gordon Belcourt, Executive Director of the Montana-Wyoming Tribal Leaders Council said, *"We are pleased and honored that SAMHSA has awarded the Montana-Wyoming Tribal Leaders Council this major grant. We are working to address the devastating impact of drug abuse, especially methamphetamine abuse on the reservations of Montana and Wyoming. This program will provide important additional resources and tools to combat substance abuse in Indian Country, and we thank the Montana and Wyoming Congressional delegation for their continued support in this battle against abuse."*

"We are working to address the devastating impact of drug abuse, especially methamphetamine abuse, on the reservations of Montana and Wyoming. This program will provide important additional resources and tools to combat substance abuse in Indian Country, and we thank the Montana and Wyoming Congressional delegation for their continued support in this battle against abuse." **—Gordon Belcourt**

Tribal and urban Indian chemical dependency programs will partner with MT-WY TLC to implement a voucher-based system. The goal is to increase access *through client choice* to an array of clinical and recovery support services. It will also include long-term planning for sustainability for local Tribal efforts beyond the grant period. Gordon Belcourt has said that the project will also give the MT-WY TLC the opportunity to fulfill one of its commitments to the Native American chemical dependency programs.

The 2007 round of grants for Access to Recovery projects (ATR II) were awarded to nineteen states and five tribal entities. To date, more than 170,000 people with substance abuse problems have received treatment and/or recovery support services through the first round of Access to Recovery grants awarded in August 2004. This exceeds the three-year target of 125,000 people.

"Providing people who have substance abuse problems with choices regarding their treatment and recovery supports makes sense," said SAMHSA Administrator Terry Cline. *"It helps empower them from the very beginning in the fight for their life."* Access to Recovery provides individuals the flexibility needed to find their own path to recovery.

In their application, the Montana-Wyoming Tribal Leaders Council delineated a process for screening and determining appropriate services for the individual client. Clients will be assessed and provided with a list of appropriate service providers from which to choose. Follow-up of clients is a priority.

"We are so excited about the responsiveness of the community. The level of cooperation and collaboration among the participants so far is very impressive. This is just the beginning and our success with this project will lead to even more support for our substance abuse treatment programs," says Kathy Masis, M.D., Project Director of RMT ATR.

Community-based providers in Montana and Wyoming will be recruited to enhance the current substance abuse treatment and recovery support system. Grass-roots, faith-based, tribal and non-tribal, public and private organizations and providers will be welcome to provide services authorized through the voucher system. The overall goal is the healthy reintegration of the individual into the family and the community.

For more information about this program, please see: www.tribalrecovery.com. *Contact RMT ATR Treatment Access Coordinator Karla Two Two, or Dr. Kathy Masis, at the Montana-Wyoming Tribal Leaders Council, (406) 252-2550.*

RMT ATR Technical Advisory Team

- *Indian Health Board of Billings*
- *Native American Indian Alliance of Butte*
- *Indian Family Health Center of Great Falls*
- *Helena Indian Alliance*
- *Missoula Indian Center*
- *Northern Cheyenne Recovery Center*
- *Crow Nation Wellness Center*
- *Ft. Belknap Indian Community Chemical Dependency Center*
- *Salish Kootenai Behavioral Health Program*
- *Northern Arapaho White Buffalo Treatment Center*
- *Eastern Shoshone Recovery Center*
- *Crystal Creek Lodge, Blackfeet Tribe*
- *White Sky Hope Center, Rocky Boys*
- *Spotted Bull Treatment Center, Ft. Peck Tribes*

Strengthening Montana

—Governor Brian Schweitzer

When I came into this office, I said that for any of us to move forward, we would all need to move forward. I still believe that. That's one reason I created the Advisory Council on Economic Security for Montana Families. The Council is made up of people with a wide range of experience, but what they have in common is the knowledge that poverty is a daily reality for far too many Montanans. They understand that many Montanans are working multiple jobs and many, many hours—and still haven't achieved economic stability. The primary tasks of the Council are to find ways to overcome barriers that keep families from secure economic futures and to look at what families really need to achieve economic security.

Economic security means having the resources you need to meet your needs without having to worry about whether or not you can pay your bills. The Council has come up with a three-part strategy. It sounds simple, but to achieve economic security, you need to earn money, you need to figure out how to keep it, then you need to grow it. *Earn it. Keep it. Grow it.*

Earning it means having skills that are in demand in the market place. We have to look at this in context with the entire educational continuum, starting with early childhood. The first step toward making sure Montanans can earn what they need is making sure kids get a good start and a good education. That's one reason I'm so excited about full-time kindergarten and school readiness strategies. The emphasis has to continue through high school graduation and beyond, to skill training. That can mean 2-year or 4-year colleges, apprenticeship programs or college, but we have to remember that the continuum runs from early childhood through adulthood.

Keeping it can be a little trickier. What it comes down to is ensuring that people have good financial literacy—the skills and knowledge they need to *manage* their money. Good financial decision making comes down to understanding credit—from when it is appropriate to borrow and under what conditions—to responsible use of credit cards and avoiding scams. Keeping it also means understanding the tools that are available. The Earned Income Tax Credit is one good example. This is generally available to working individuals who make less than $12,000 and families earning less than $40,000; child tax credits worth up to $1,000 per child are also available. Preliminary IRS figures show that in 2006, nearly 72,000 Montana households received more than $124 million in earned-income tax credit refunds.

Growing it means taking your earnings and coming away with assets, investing in the things that increase rather than depreciate in value. One of the best growth strategies yet is *Individual Development Accounts* (IDAs). These are matched savings accounts that help families who meet income-based criteria save, build assets and enter the financial mainstream. IDAs are being administered by a number of savings institutions and human service organizations around the state*. Say a family gets an earned income tax credit refund of $3,500. If half goes into an IDA and a little is added on top of that each month, every dollar contributed can be matched in a parallel account that can be used to buy a home, get post-secondary education or start a business. It means that no one is shut out of the American Dream. And that's what I'm talking about when I say that *Montana is on the move.*

**For more information on where to look for IDAs in your community, visit the Corporation For Enterprise Development at http://www.cfed.org/focus.m. Follow the Individual Development Account link. At the bottom of the page is a link to an online directory by state.*

Governor Schweitzer and Montana's Economic Success

In a February 2008 article, The Economist magazine says that "Montana's economy is in better shape than it has ever been." According to the article, Montana has had one of the fastest rates of job growth in the country. The state is prospering on the back of booms in mining and farming, as well as steady growth in tourism.

Paul Polzin of the University of Montana forecasts that the state's economy will grow by 4.1 percent this year, the fifth consecutive year of growth above 4 percent. "We've been searching for realistic doomsday scenarios," he says, "and we just can't find any."

For more information, visit Governor Schweitzer's website and click on the link to the full article. http://governor.mt.gov/

The Last Word

—Joan Cassidy, Chemical Dependency Bureau Chief

We can define *prevention* as a proactive, evidence-based process focused on increasing the protective factors and decreasing the risk factors associated with alcohol and drug abuse and other behaviors that can put youth in jeopardy. Both risk and protective factors can be defined in terms of individual, family, peer, school and community domains.

The Addictive and Mental Disorders Division's approach to alcohol and substance abuse prevention—and to the conceptual framework that supports it—is based on national research findings and our state's experience in program development, implementation and evaluation. Current research proves that effective prevention includes evidence-based strategies for addressing risk and protective factors across the domains. Strategies must be deliberate, applied at the appropriate levels of intensity and in appropriate settings, from homes to schools, and from workplaces to community venues.

We look at prevention as a *process* designed to reduce risk factors and enhance protective factors. We also look at it as a continuum, as is clearly demonstrated in this newsletter. We are excited about the Strategic Prevention Framework State Incentive Grant (SPF SIG) highlighted in this issue. At the other end of the continuum, we are equally excited about the new Resident Treatment Expansion Consortium (RTEC), which will provide appropriate treatment to people who are addicted to methamphetamine and other substances. Those programs will help provide people with the tools they need to regain their lives. In this case, intervention is also prevention. While in treatment, residents of the RTEC facilities will learn the parenting and life skills they need to help them improve their *children's* chances for healthy life outcomes.

Folk wisdom tells us that children live what they learn. *Science* tells us that being raised with extreme economic privation is a risk factor for delinquency, violence, early pregnancy and school dropout. Science tells us that children who live in families with histories of addiction to alcohol or other drugs are at much higher risk of developing alcohol and other drug problems of their own, and that children raised in families with histories of criminal activity run a much greater risk of juvenile delinquency. We know that addiction within the family system can lead to a host of issues that range from poor family management practices and severe, persistent conflict to favorable parental attitudes toward a host of negative attitudes and behaviors. Our efforts through RTEC are designed to move people beyond addiction and into healthy, productive lives. This means healthier family systems and, ultimately, better outcomes for children, families and communities. It's win-win.

American author and lecturer Marianne Williamson once said, "*In every community there is work to be done. In every nation, there are wounds to heal. In every heart, there is the power to do it.*" This issue of the *Prevention Connection* illustrates not only the work to be done and the wounds to be healed, but the incredible power coming to play throughout Montana as we build the foundation needed to do the work and heal the wounds.

CSAP Center for Substance Abuse Prevention
Substance Abuse and Mental Health Services Administration

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